OFFICE OF INSPECTOR GENERAL

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Semiannual Report

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INSPECTOR GENERAL

OIG Semiannual Report
October 1983 — March 1984

EXECUTIVE OVERVIEW

In fiscal year 1984, the programs of the Department of Health and Human Services (HHS) will cost the taxpayers $292.2 billion. The goal of the Office of the Inspector General is to promote the economy and efficiency of these programs and reduce the incidence of fraud and abuse. During the first half of this year, our major accomplishments were:

- As a result of OIG efforts and recommendations, a total of nearly $1.8 billion in management commitments to recoveries and savings was achieved.

- Criminal investigations resulted in over 400 convictions of Medicare and Medicaid providers and suppliers, Social Security beneficiaries, grantees, contractors and others attempting to defraud Departmental programs.

- Another 180 criminal convictions resulted from the State Medicaid Fraud Control Units also funded by the OIG.

- A further result of OIG investigations was nearly $15 million in fines and penalties being levied against wrongdoers.

- The OIG sanctioned (i.e., removed) 234 health providers and suppliers from the Medicare and or Medicaid programs for fraudulent or abusive practices.

- Civil Monetary Penalties settlements were made with total recoveries and settlements of over $2 million.

The OIG has sought to strengthen the public's confidence in the integrity of HHS programs by preventing and detecting acts of fraud and abuse. In addition to standard investigative and prosecutive methods, we are employing a wide range of approaches, including administrative sanctions and Civil Monetary Penalties Law (CMPL) authority. The results have been impressive. The number of sanctions during this period exceeded the total for the entire previous fiscal year and our CMPL cases began yielding significant returns.

The OIG is also devoting considerable attention to the review of programs to recommend ways in which they can operate with greater economy and efficiency. These program reviews are targeted for areas of particular importance or special vulnerability to waste. Using the findings of these reviews, we often develop recommendations for improved regulations and legislation. These recommendations help prevent or correct deficiencies that might otherwise remain undetected until future reviews disclose that HHS funds have been inappropriately spent or fraud or abuse has occurred.

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OIG OPERATING HIGHLIGHTS

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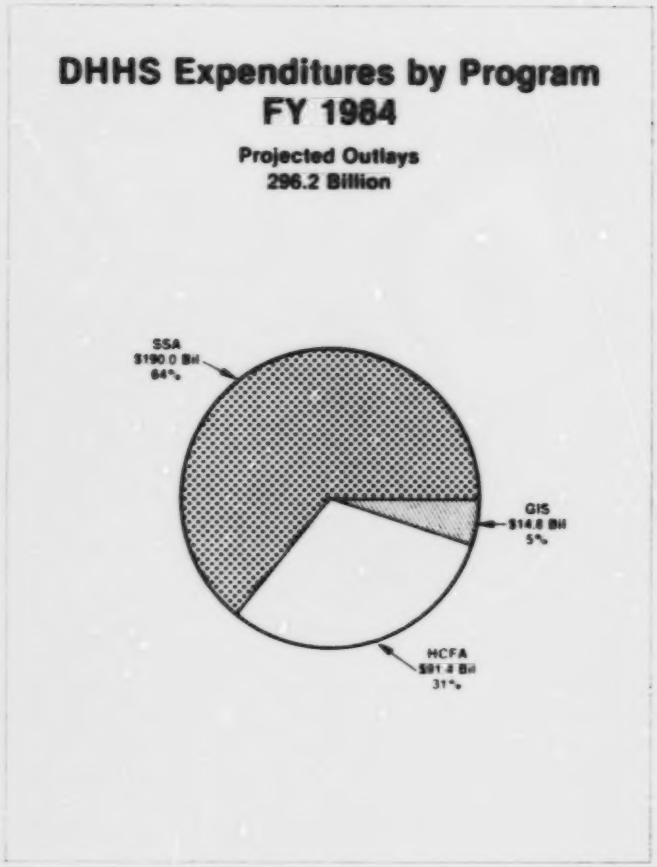
CHAPTER I

OIG OPERATING HIGHLIGHTS

This is the Semiannual Report of the Department of Health and Human Services' (HHS) Inspector General's office which describes major OIG accomplishments during the period October 1983–March 1984. In FY 1983, the Department spent $276.8 billion and that is expected to grow to $296.2 billion in FY 1984. The following chart shows the breakout of these funds among major Departmental programs (Health Care Financing Administration, Social Security Administration, and Grants and Internal Systems):



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The goal of the OIG is to promote the economy and efficiency of these programs and to reduce the incidence of fraud and abuse. In pursuit of this goal, we continued our efforts to concentrate limited resources on the areas of greatest vulnerability and highest possible return. This report contains an overview of these areas of concentration and of the actions taken by the Department and Congress as a result of our recommendations. The report clearly indicates that there were impressive results from this strategy. Thus during this 6-month period OIG activities had financial results of almost $1.8 billion—more than was saved during the entire previous fiscal year.

REPORT STRUCTURE

This report is organized into chapters which correspond to the major departmental programs. In addition, there are chapters on Legislative and Regulatory Review and the President's Council on Integrity and Efficiency. In general, each item describes: (1) what we reviewed studied investigated; (2) what we found; and (3) what has happened as the result of our work. Following are highlights of these chapters.

Health Care Financing Administration

- The OIG "kicked out" 234 health providers from the program(s) for engaging in abusive and fraudulent practices. In addition, investigations of Medicare Medicaid fraud resulted in over 200 convictions and recoveries of almost $9 million. (See pages 18, 19)

- Elimination of duplicate charges for health services provided in a teaching setting could save Medicare a possible $90 million annually. (See page 8)

- Savings of $71 million annually are possible with better curbs on Medicaid prescription drug costs. (See page 9)

- Changing the frequency of pacemaker monitoring could save Medicare about $64 million annually without impacting on the quality of patient care. (See page 9)

- Implementation of recommendations regarding collection agency fees and bad debts reimbursement would save approximately $35 million annually. (See page 15)

- Applying the "multiple visit" concept to physician visits to beneficiaries in

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skilled nursing homes could save Medicare $31 million annually. (See page 7)

- Use of effective computer edits would prevent a $20 million annual overcharge to Medicare for outpatient claims. (See page 10)

- Changes in reimbursement for treatment of mycotic nails would save Medicare at least $10 million annually. (See page 15)

- OIG recommendations on utilization review led to substantial improvement of the new Peer Review Organization (PRO) contracts. (See page 10)

Social Security Administration

- OIG investigations of Social Security fraud resulted in over 300 convictions and over $5 million in financial results. (See page 35.) An additional 80 AFDC convictions and almost $1 million in recoveries resulted from joint investigations with State agencies. (See page 36)

- Congressional action taken to accelerate State and local deposits of Social Security contributions will increase Trust Fund interest income and contribution receipts over the next 5 years by $496 million and $836 million, respectively. Further acceleration of these deposits could increase interest income and contribution receipts by an additional $1.468 billion. (See page 39)

- Elimination of overlapping Federal benefit payments could save $30.5 million annually. (See page 30)

- Matching bank records with the records of public assistance recipients could result in first year savings of $298 million and recurring savings of $161 million annually. (See page 30)

- Prompt action following a legal judgment on disability could save $68 million annually. (See page 32)

- Charging for the replacement of lost or misplaced Social Security number cards could save SSA an estimated $46 million annually. (See page 30)

- Allowing SSA District Offices to process additional disability claims could

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save SSA $10 million annually and speed up beneficiaries' claims. (See page 32)

- Over $10 million could be saved by resolving the unverified cash refunds and returned checks in the SSI program. (See page 33)

Grants and Internal Systems

- Expanding job opportunities and community integration for developmentally disabled adults could save $200 million annually. (See page 48)

- More economical purchasing of medical supplies could save PHS about $13 million annually. (See page 46)

- Investigative efforts in the GIS area resulted in over 20 convictions and over $300,000 in recoveries. (See page 53)

- Technical improvements could double the accessibility of the National Runaway Switchboard without additional cost. (See page 48)

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HEALTH CARE FINANCING ADMINISTRATION

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CHAPTER II

HEALTH CARE FINANCING ADMINISTRATION

The Health Care Financing Administration (HCFA) was established in 1977 to combine administration of the Medicare and Medicaid programs. Medicare finances health services for persons aged 65 and over and for disabled persons. Medicaid provides matching funds to States to finance medical services for low income persons who are in families with disabled, dependent children or who are aged, blind or disabled. Expenditures for Medicare and Medicaid amounted to $88.9 billion in FY 1983. Medicare paid over $36.8 billion for hospital care alone and another $1.5 billion for home health care.

OIG ACCOMPLISHMENTS

In our continuing effort to curb spiraling Federal health care costs, the OIG has devoted considerable resources to HCFA review, concentrating on systemic problems in the Medicare and Medicaid programs. During the first 6 months of FY 1984, we identified four areas where savings of over $256 million could be achieved if legislation or, in some cases, regulations are changed to correct identified problems. In addition, we recommended financial adjustments of $79.5 million in the HCFA area.

During the report period, we have continued to stress front-end reviews of program areas with the potential for becoming costly mistakes. Our current focus is on capital costs of medical facilities—and how such costs should be incorporated into Medicare's new prospective payment system.

This chapter is divided into: (1) legislative/ regulatory reform; (2) program administration; (3) program payments; (4) ongoing reviews in health; (5) administrative sanctions; (6) investigative activities; (7) computer applications; and (8) recommendations not yet acted upon.

Legislative/Regulatory Reform

OIG reviews identified four specific program areas where over $256 million could be saved annually with legislative or regulatory reform.

MULTIPLE PHYSICIAN VISITS

In 1970, the Department decided to reduce physician reimbursement for intermediate care visits when more than one patient is seen during the same visit to a nursing home. The Department based this action on the fact that

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(1) the level of services rendered in a nursing home setting is ordinarily comparable to those furnished in an office setting and (2) the physician realizes savings in time and money by seeing a number of patients in one place, especially since the physician has the advantage of having the facilities and personnel of the nursing home available.

The Department emphasized that Medicare carriers needed to make similar adjustments in their charge determinations for physician visits to Skilled Nursing Facilities (SNFs) and hospitals. However, almost 14 years have passed since the institution of the "multiple visit" provisions and no action has been taken to expand them to SNFs or hospitals. HCFA officials state a higher reimbursement rate is justified for visits to patients in SNFs and hospitals. Further, HCFA believes that extension of the "multiple visit" policy would cause a number of problems including a negative effect on physician willingness to attend Medicare patients.

Application of the "multiple visit" concept to SNF visits could save Medicare about $31 million annually or $154 million over a 5-year period. Long-range savings would be significantly higher as the number of nursing home patients is expected to more than double by the year 2003. Savings to the Medicare program would be higher still--an additional $304 million annually, or $1.5 billion over a 5-year period—if the "multiple visit" concept is applied to physician visits to hospital patients.

RESIDENTS/ TEACHING PHYSICIANS

The Medicare program has always paid the costs of approved intern and resident programs at teaching hospitals as part of the institutions' cost of providing patient care. Typically, after the first year or so of postgraduate training, residents are licensed physicians. They provide physician care to patients under progressively less direct supervision as their experience and competence increases. In some cases, residents provide essentially all of the physician services received by a patient. However, Medicare policies will not recognize residents as physicians for the purpose of reimbursement; only the charges of the teaching physician are covered. Thus in a teaching setting, Medicare pays twice for the same service—once as a charge for the teaching physician and again as part of the hospital cost for the resident's salary.

We estimate these duplicated Medicare costs to be about $90 million annually. We plan to recommend changes in Medicare to allow only a single charge-based reimbursement for physician services, and that the costs of licensed residents not be reimbursed as a hospital cost.

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PRESCRIPTION DRUG COSTS

Based on reviews in six States and inquiries in 41 others, we estimate that Medicaid could save about $71 million annually if States adopt alternatives to industry-published average wholesale prices (AWP) which they currently use in estimating prescription drug ingredient cost. Our reviews found that most States continue to use the published AWP without giving recognition to discounts offered pharmacies, which usually buy drugs at prices discounted below AWP. We also found that HCFA has allowed States too much flexibility in estimating ingredient costs.

Our recommendations to HCFA will call for (1) precluding the general use of published AWP as the State agency's best estimate of what providers generally are paying for drugs and (2) encouraging State agencies to aggressively pursue alternative methods for establishing drug ingredient cost.

PACEMAKER MONITORING

Presently, Medicare guidelines allow monthly monitoring of pacemaker patients, either at a clinic or electronically by phone. We examined the Medicare payment history listings for 522 randomly selected pacemaker patients. We found that 421 (81 percent) were monitored by phone. The other 101 patients were monitored clinically on an average of only 4.4 times per year.

Further, data on telephone monitoring frequency strongly suggests that many physicians and monitoring firms monitor patients as frequently as the Medicare reimbursement guidelines allow—basically monthly. We also found that telephone monitoring is usually a routine procedure with little or no physician involvement and thus more properly classified as a routine medical service than a physician service. Physicians we interviewed advised us that telephone monitoring frequency could be reduced. Most pacemaker patients are not totally dependent on their pacemakers for basic functioning of the heart. Even if the worst scenario occurs and a patient's pacemaker shuts down, the patient would most likely continue to function at a reasonable level. It may also be a psychological burden to an elderly Medicare patient to be told that the pacemaker has such a high risk of malfunction that it must be monitored monthly.

We believe Medicare Part B could save $64 million of the $126 million it spends on pacemaker monitoring each year by (1) limiting its guidelines for the reimbursement of phone monitoring to the significantly less frequent schedule recommended by the Department's Office of Health Technology Assessment and (2) reclassifying this service as "routine" rather than the current "physician service," thereby reducing reimbursement amounts.

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Program Administration

OIG reviews identified several areas where over $22.1 million savings would result with more efficient program management and tightened fiscal and internal controls. In addition, another $79.3 million were identified as questionable program expenditures requiring appropriate financial adjustment. We also reviewed HCFA's efforts to minimize year-end procurements, its internal control initiatives under OMB Circular A-123, and the impact of the "Working Aged" provisions on Medicare costs.

IMPROPER CLAIMS PROCESSING

We found that more than a third of Medicare intermediaries did not have the necessary computer edits to concurrently review hospital inpatient and outpatient claims to detect and preclude payments of claims for hospital outpatient services that should have been treated as inpatient care. Unless actions are taken to preclude such payments, we estimate Medicare will be overcharged $20.3 million annually for outpatient costs that would be covered under Medicare's new prospective payment system.

We recommended a concerted effort by HCFA to ensure effective payment controls are in place at all intermediaries. HCFA agreed to issue instructions to assure that intermediaries develop the appropriate processes to detect duplicate bills.

COSTLY DATA TRANSMISSION

HCFA could save an estimated $12.5 million over a 7-year period (or about $1.8 million annually) by redesigning its telecommunications system.

Currently, there are two general methods that carriers and intermediaries use in transmitting and receiving beneficiary and billing data (1) direct transmission to HCFA or (2) indirect transmission through a private contractor which is substantially more costly. Specifically, in FY 1983, although only 40 percent of the workload was transmitted indirectly under contract, the cost was $2.2 million or more than twice the cost of the direct process.

We are recommending that HCFA terminate the telecommunications portion of its contract and redesign its telecommunications network so that all data will be transmitted directly to HCFA.

UTILIZATION REVIEW

We recently studied the Utilization Review (UR) efforts of States and private corporations to determine what lessons their experiences might offer for Medicare and Medicaid Utilization Review. We found that (1) many State and private contacts urged that HHS focus its utilization review resources on inappropriate hospital admissions and diagnoses miscoding to control

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abuse in the new Prospective Payment System and (2) many State Medicaid agencies and many major corporations turn more frequently than Medicare to pre-service UR and believe Medicare should require more pre-service UR.

We recommended that HCFA should require its contract Peer Review Organizations (PROs) to: (1) focus on certain types and patterns of hospital admissions and re-admissions; (2) employ pre-admission screening of selected hospital inpatient services; (3) verify a specific sample of cases for miscoding of diagnoses; and (4) review hospital instructions concerning medical review and record coding.

The Department and the Office of Management and Budget (OMB) have used this study and related work to alter substantially the new PRO contract specifications. Based on State and private sector experience, the use of pre-admission screening by Medicare could save hundreds of millions of dollars annually.

PREFERRED PROVIDER ORGANIZATIONS

The Preferred Provider Organization (PPO) is a new alternative health delivery and financing system with possible implications for Medicare and Medicaid cost-containment. We examined PPOs and found that they are still in their early stages of development and that while there are some examples of short-term savings, there are no long-term data to demonstrate cost-effectiveness of PPOs. We also found that while some PPOs seem cost-effective, many questions remain. We are continuing to study this developing area by performing a feasibility study for applying the PPO concept to physicians in Medicare Part B and by planning a program inspection to determine the implications of PPOs for Medicare and Medicaid cost-containment.

EXCESSIVE ADVANCES

Reviews in two States disclosed improper claims totaling $10 million for funds advanced to Intermediate Care Facilities (ICFs). The claims were improper because the advances did not represent reimbursement for actual expenditures incurred. Instead, advances were made to alleviate cash flow problems at these institutions and were in addition to payments for actual services provided by ICFs. Recommendations called for appropriate financial adjustments and for States to discontinue this practice.

UNCERTIFIED ICF/MRs

An OIG review found that one State improperly claimed Medicaid reimbursement totaling $45.5 million for care provided mentally retarded patients: (1) housed in facilities that had never been surveyed and certified, or issued valid provider agreements; (2) in sections of facilities that had been excluded from the facilities' total certified bed capacity; or (3) numbering in

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excess of a facility's certified bed level. The improper claims covering about a 7-year period, occurred primarily because different State agencies, with differing responsibilities in the mental health area, did not establish an oversight mechanism to assure completion of tasks necessary to gain or renew certification.

In addition to financial adjustments of $45.5 million, we recommended procedural changes to improve the State's ability to control and monitor the certification process. Regional HCFA officials concurred with our management recommendations and with all but $15 million of our proposed financial adjustments, pending a policy decision from HCFA headquarters.

ICF/MR RATES OIG activities in three States disclosed that per diem rates used to reimburse ICF/MRs were incorrectly determined and resulted in overcharges to the Medicaid program totaling $12.9 million.

In one State, we found that costs attributable to prior years were improperly included in the FY 1981 cost base used to determine prospective per diem rates for State-owned and operated ICF/MRs. As a result, the rates were overstated and ICF/MRs were overpaid about $1.65 million. We also noted that the State did not have an approved plan for charging indirect costs to the Medicaid program. Indirect costs inappropriately claimed totaled $3.3 million. In another State, ICF/MR reimbursement rates were overstated due to duplicate payroll charges totaling $352,000. Appropriate financial adjustments and procedural changes were recommended.

In a third State a prior OIG review, covering fiscal years 1977 through 1979, noted two major problems related to Medicaid reimbursement to ICF/MRs. OIG found that procedures for (1) screening costs against Federal regulations were not adequate to ensure that reimbursements to ICF/MRs were reasonable and allowable, and (2) computing and applying per diem rates were not consistent. Recommendations called for the State to improve these procedures and refund $7.5 million in questioned costs. During a current follow-up review, OIG found that the State had refunded the questioned costs and, in July 1982, revised and expanded its procedures to correct the noted deficiencies. However, the State did not retroactively adjust their fiscal years 1980 and 1981 final cost settlements with ICF/MRs to reflect the revised procedures. This resulted in the Federal Government being overcharged $7 million.

We recommended a financial adjustment of $7 million and procedural changes to preclude the claiming of similar unallowable costs in fiscal year

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1982 and future years. Regional HCFA officials concurred with our findings and recommendations.

MEDICAID RECOVERIES

OIG identified instances where three States failed to properly credit the Medicaid program for its share of recoveries. In one State, overpayments totaling $6.7 million had not been credited to Medicaid primarily because the State's policy (contrary to Federal regulations) was to defer crediting the Federal account until overpayments were actually collected from providers. In two States, $916,000 of interest earned on recovered overpayments were not refunded to the Federal account. Recommendations called for appropriate financial adjustments and procedural changes.

MEDICARE CONTRACTOR COSTS

During this 6-month period we assessed the allowability of administrative costs incurred by Medicare intermediaries and carriers and recommended disallowances of $2.0 million in costs considered unallowable for reimbursement.

Unallowable costs included: improper pension costs; costs for a computer system that was never implemented; and overcharges primarily due to inequitable allocation methods.

YEAR-END PROCUREMENT SPENDING

In an effort to eliminate wasteful year-end spending, Operating Divisions within the Department are not to award more than 30 percent of their annual procurement obligations during the last quarter of any fiscal year. HCFA has not met this Departmental standard for 3 of the last 4 years.

We assessed the adequacy of HCFA's efforts to minimize FY 1983 fourth quarter procurement actions. We found no evidence of money being spent on unnecessary goods or services. However, we found their efforts unsuccessful, due in large measure to a lack of emphasis by management on proper procurement scheduling. We found such problems as acceptance of proposed costs without meaningful cost/price analyses, inadequate time for competition leading to unjustifiable sole source awards, and the "banking" of expiring appropriated funds through modifications to existing contracts.

Our recommendations will call for procedural improvements that (1) minimize instances of excessive year-end spending and (2) assure that all procurement actions comply with existing Federal and Departmental directives.

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INTERNAL CONTROLS INITIATIVE

In line with the Administration's Reform 88 initiative to strengthen internal controls and OMB Circular A-123, "Internal Control Systems," we evaluated 15 internal control reviews (ICRs) performed by HCFA. In general, HCFA's ICRs met OMB and Departmental requirements. We noted, however, that only three regional offices had been included in these reviews and we recommended that all ten be reviewed due to the autonomy of each office.

Further, we recommended that HCFA include Medicare intermediaries and carriers in the A-123 initiative because of their unique and significant role as paying agents of Medicare claims which totaled over $54 billion in FY 1983—and which are expected to increase to $74 billion in FY 1985. Although, under OMB and Departmental directives, HCFA is not required to include contractors in its A-123 internal control reviews, we believe the Medicare intermediary/carrier function is an extension of HCFA operations and warrants inclusion in HCFA's planned ICRs.

WORKING AGED

In 1982 Congress required most employers to make their health plans available to employees who are 65-69 and to their spouses. If such coverage is chosen, the health plan rather than Medicare would have primary liability (first payor) for services provided under the plan. The Department estimated the working aged provisions would save Medicare $315 million in FY 1984.

Our review at six intermediaries and three carriers found little evidence that these provisions were producing anticipated savings. Eleven months after implementation, contractors reviewed had not identified a single claim that was fully paid under an employer health plan and only 15 claims partially paid. We believe this poor showing is due in large part to the heavy reliance placed on providers to initially identify beneficiaries covered by employer health plans. Past studies have shown that millions of dollars in third party resources are lost to the Medicare program every year, much of it due to providers failing to identify third party medical insurance resources.

To maximize cost savings to Medicare, we recommend that HCFA increase its existing efforts to see that intermediaries and carriers rely on front-end controls to flag those beneficiaries who are also covered by employer-sponsored health plans.

Program Payments

In addition to evaluating program administration, we examined specific types of program payments and a number of individual providers under

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Medicare and/or Medicaid. We identified $86 million in overpayments and cost avoidances through this activity.

COLLECTION AGENCY FEES

We examined a group of hospitals in one region and found that not all were referring their Medicare uncollectible accounts to collection agencies even though these accounts often met the hospitals' normal referral criteria. As a result of our findings, HCFA issued clarifying instructions regarding uniform treatment of collection agency fees and bad debt reimbursement. We estimate this action will save Medicare over $35 million annually.

MYCOTIC NAILS

As a continuation of our review of the mycotic nails area we found that the Medicare program was being billed for cutting of nails that were not truly mycotic, debridments were being performed more often than medically necessary and podiatrists with a nursing home practice billed more frequently than those with an office practice. We recommended HCFA limit treatment of mycotic nails to that which is therapeutic; require podiatrists to identify on the bill which nail was avulsed, and impose a 60-day utilization guideline for both debridment and avulsions. As a result of these recommendations, we estimate the Medicare program will save approximately $10 million annually.

FLOTATION PADS

We examined the coding and pricing of flotation pads in one State and found that the Medicare carrier had only one code for the processing of all claims for flotation pads. This code was established when there was only one pad, (the Stryker pad), to meet this health need. This pad had a $65 rental fee and a $260 purchase price. Subsequently, other pads were developed which cost less but the carrier still used the single code. As a result of our efforts the carrier took corrective action and established four new pad codes. It is estimated these new codes will save approximately $1 million annually.

ANESTHESIA AND ASSISTANT SURGERY

We examined the coding for certain services by the Medicare carrier in one State. We found that anesthesia and assistant surgery services were coded in such a manner that they were reimbursed at a higher than normal rate. Based on our findings, the carrier modified its prepayment edit definitions. This modification has resulted in annual savings of over $800,000.

PHYSICIAN VISITS TO NURSING HOMES

We examined physician visits to nursing home patients in one State. We found the billing codes the carrier used to process the bills for this type of visit were resulting in inappropriate reimbursement to the physicians. To solve the problem, we recommended modifications to the billing codes as well as development and implementation of a new Medicare edit to ensure

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that per visit charges are appropriate. HCFA agreed with our findings and is developing appropriate visit codes and a Medicare edit. We estimate these changes will save almost $700,000 annually.

OXYGEN SUPPLIERS

We examined the billing practices of four oxygen suppliers in one State. We found that they had billed for the use of the equipment after it had been returned, improperly identified the place of service, billed for disposable humidifiers or billed for standby systems. As a result, HCFA has issued instructional letters clarifying the policies on billing for disposable humidifiers and for standby systems. These new instructions should result in savings of approximately $275,000 annually.

AMBULANCE TRANSPORTATION SERVICES

We also reviewed ambulance transportation services for Medicare beneficiaries in a metropolitan area. We found that 65 percent of the trips reviewed in the claims sample did not meet the medical necessity requirements for ambulance services. As a result of this inspection, $250,000 were identified in savings.

PROVIDER REVIEWS

A few of the more significant cases of our provider reviews were:

- A hospital in Georgia was overpaid in excess of $675,000 due to the hospital's failure to properly distribute general service costs, expensing as repairs and maintenance capital improvements to the building, and reporting the contract expenses of its leased laboratory as hospital laboratory costs.

- A hospital in Florida was found to be overpaid in excess of $77,000 due to the hospital reporting a percentage of non-covered charges for patient use of oxygen as a program cost.

- A proprietary hospital in Florida was overpaid over $52,000 by billing for non-covered respiratory therapy services.

Ongoing Reviews In Health

Prevention is a major theme of OIG activity: Our aim is to prevent potential problems rather than recommend remedies for damage caused by their occurrence. Consequently, we are devoting considerable effort to front-end reviews of areas that have the potential of becoming costly mistakes. Following are highlights of several of these reviews.

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CAPITAL COSTS

The Social Security Amendments of 1983 changed the method of payment for Medicare inpatient hospital services so that the payment amount is determined prospectively for each discharge. However, capital expenses, such as interest and depreciation, will continue to be reimbursed on a reasonable cost basis until at least October 1, 1986. After October 1, 1986, capital expenses will no longer be excluded from the prospective payment system if a method acceptable to Congress for including these costs is found.

Consequently, we are working with Departmental officials to assist in efforts to improve current Medicare and Medicaid policies for paying capital costs on a reasonable cost basis and to establish an effective method for incorporating payments for capital costs into the prospective payment system. As indicated in the following, we are looking at current problems in the area of capital costs from a variety of perspectives.

- **PURCHASE OF MEDICAL FACILITIES**

  Preliminary results of our review of depreciation and interest expense reimbursed under Medicare and Medicaid show that purchases of used medical facilities are usually made at prices far in excess of the sellers' book values of those assets—and often even in excess of the sellers' acquisition costs. The result is higher subsequent costs to all parties purchasing care at those facilities. Policies adopted by some States limit Medicaid's recognition of such increases in capital costs. Although our study is continuing, we have provided preliminary information to HCFA and the Assistant Secretary for Planning and Evaluation (ASPE) because of its pertinence to the overall consideration of capital costs.

- **GAINS FROM PROVIDER SALES**

  We also advised HCFA that proprietary providers were incorrectly applying Federal regulations when computing Medicare's share of gains from sales of hospitals and nursing homes. At one intermediary alone, we found Medicare's share of gains was improperly reduced by $1.4 million. We suggested that HCFA remind all intermediaries of the proper procedures for treating gains on sales of medical facilities and instruct intermediaries to reopen cost reports, where necessary, and compute the proper Medicare reimbursement.

- **HILL-BURTON FINANCED PROVIDERS**

  From 1946 until 1974 Hill-Burton funds provided a total of $4.4 billion in Federal dollars for building and modernizing health facilities. Medicare regulations and most State Medicaid programs provide for an allowance for depreciation on assets even though they were financed with Hill-Burton or other Federal funds. This practice results in double payment for health facilities.

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We pointed out to HCFA an opportunity to save Medicare and Medicaid over $700 million by eliminating depreciation allowances on assets financed with Federal funds under the Hill-Burton program. HCFA has the authority to change its current policy without seeking legislative changes.

EQUITY CAPITAL

- In addition to these activities, we plan to examine the question of whether return on equity capital (REC)—generally the amount invested by owners—should continue to be a reimbursable cost. We will evaluate the pros and cons of REC as well as the consequences of inclusion/ exclusion of REC from the prospective payment rate.

On March 21, 1984, the Inspector General testified about these audits before the Subcommittee on Health and the Subcommittee on Oversight of the House Committee on Ways and Means. Pending the inclusion of capital costs in a hospital prospective payments system, the Inspector General recommended a moratorium be imposed by Congress on asset revaluation after hospital sales, to prevent Medicare from recognizing increases in the cost of facilities for reimbursement purposes.

LABORATORY SERVICES

Preliminary results of a nationwide review of Medicare laboratory services disclosed: kickbacks to physicians for Medicare referrals; claims for services not rendered; and price discrimination against Medicare. We previously reported similar findings in the Medicaid program. Currently, a HCFA task force is looking into this matter and in a proposed final report recommended that (1) Medicare pay for laboratory services on the basis of a national fee schedule and (2) assignments of claims for such services remain voluntary, i.e., leaving the provider the option of accepting Medicare payment as fee for service. While OIG supports the concept of a national fee schedule, in our opinion, the methodology proposed by the HCFA task force to establish such fee schedules will result in inflated prices. As for leaving assignments voluntary, we believe any reductions in Medicare-paid laboratory costs without mandatory assignments may very well result in physicians/labs passing on inflated costs to beneficiaries. Our review is continuing.

Administrative Sanctions

In the war on fraud and abuse, one of our most effective weapons is the sanctioning of providers and practitioners by removing them from the program(s). In the first 6 months of this fiscal year, 234 providers and practitioners were sanctioned. Over 78 percent of these suspensions were for 3 years or longer. Some of the more significant sanctions were:

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- The highest paid Medicaid provider in New York was excluded under Section 1862(d)(1)(C) of the Social Security Act due to his long-standing and consistent pattern of over-utilization of services and poor quality of care. This physician had received over $1 million from Medicaid during 1983.

- A pharmacist was suspended from Medicare and Medicaid for 30 years due to his conviction for submitting invoices for prescriptions that had not been filled and for entries on invoices containing false information concerning the type, quantity, dosage form or strength of various medications.

- A nursing home administrator was suspended for 10 years as a result of his conviction for larceny and perjury relating to his participation in the Medicaid program.

- A psychiatrist was suspended for 10 years as a result of her conviction for billing for psychiatric services which were not provided.

- A pharmacist was suspended from the Medicare and Medicaid programs for 5 years due to his conviction for substituting generic drugs for brand name equivalents which were billed to the State.

- A nursing home operator was suspended for 10 years due to his conviction for submitting fraudulent reports.

- A physician was suspended for 10 years based on his conviction for grand theft involving the Medicaid program.

- A taxi service operator was suspended for 8 years based on his conviction for submitting false Medicaid claims.

- The owner of a pharmacy was suspended for 10 years based on his conviction for submitting false Medicaid claims.

Investigative Activities

DETECTING HEALTH CARE FRAUD

Investigative emphasis on health care fraud and abuse continued during the first half of FY 1984. Our goal is to direct over half of our investigative resources towards health care cases, primarily Medicare. We have also engaged in cooperative investigations with other Federal agencies such

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as the FBI and Postal Inspectors. Within the past year, we have initiated several proactive projects to also detect fraud in certain segments of the health care industry or specific areas of the country.

As a result, OIG investigations of health care fraud resulted in 26 convictions, 18 civil monetary penalties settlements and 2 administrative actions. These efforts resulted in fines and restitutions of over $930,000, recoveries of $332,000 and penalty savings of $1.9 million. We obtained another $2.1 million from 12 civil monetary settlements plus another $270,000 in savings. In addition, the Medicaid Fraud Control Units obtained over 180 convictions and over $2.1 million in fines and restitutions. (See page 22)

ECONOMIC CRIME COUNCIL

An important cooperative event occurred during this period when the Economic Crime Council of the Department of Justice invited us to participate in a new initiative. The Council is placing a high priority on Medicare prosecutions and has a commitment from U.S. Attorneys throughout the nation to handle Medicare cases expeditiously. Our investigators will refer to OIG headquarters Medicare cases for which they have difficulty obtaining local prosecution action. Working through the Council, we hope to achieve more and quicker prosecutions.

COMPETITOR LEADS

Doctors and pacemaker competitors wrote the OIG complaining that a company was offering physicians "rebates" of $100 or more for each of their products used. Our investigation developed an important national case which was referred to the FBI for investigation. The pacemaker company, a former company president and two other company officials pled guilty to paying more than $140,000 in kickbacks of cash and gifts to doctors who bought their products.

Competitors and former employees accused an Ohio ambulance company owner of committing Medicare fraud. He was subsequently convicted and sentenced to 5½ years in jail, 3 years probation and a $10,000 fine for transporting patients to a renal dialysis center in an ambulance when they did not need emergency services, and then billing Medicare.

CARRIER CASES

Medicare carriers not only detect evidence of fraud when processing claims, but also receive complaints from patients about questionable billings which are referred to the OIG for investigation. The following convictions were obtained as a result of this process.

- A Texas anesthesiologist had billed Medicare for post-operation respiratory distress syndrome treatments, but hospital records showed no evi-

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dence of such services. The physician was convicted and given a 2-year suspended sentence, ordered to make restitution on 28 claims and told to perform 250 hours of community services.

- A Texas inhalation therapist on contract to a hospital was found to be billing Medicare $35,000 for services never provided. He was convicted and sentenced to 4 years in jail.

- In Pennsylvania a beneficiary was found to have altered bills for colostomy and ileostomy supplies. The beneficiary had bought about $1,500 worth of supplies, while claiming to have paid more than $23,000. Convicted of fraud, the beneficiary was sentenced to 2 years probation. A civil suit is underway to recover the Government's losses.

- A Florida chiropractor billed Medicare for spinal manipulations after x-raying, none of which he performed, and for equipment not needed. He was convicted on 4 counts of fraud and sentenced to serve 3-year jail terms for each.

- A Detroit ambulance company owner was convicted for billing Medicare and Medicaid for transportation of psychiatric patients in ambulances when they were actually batch-transported in standard factory-equipped vans. He was convicted and sentenced to 1 year and 1 day in prison and 5 years probation on the condition that he repay $40,000 to Medicare and $80,000 to Medicaid. He was also fined $1,000.

AUDIT LEAD

We investigated questionable Medicare charges of a medical supply company uncovered during an OIG audit. Three company officials were convicted for billing Medicare for nutrients and other supplies which were never delivered to nursing home patients. The company president was convicted and sentenced to serve 4 years in prison and fined $15,000. The other two officials were sentenced to 2 years and 6 months in jail, respectively, and ordered to pay $5,000 fines each. The Government has already been repaid almost $600,000 from the company and has withheld payment of about $82,000.

COOPERATIVE EFFORTS

The new director of a home health agency became suspicious of the cost reports filed by her predecessor. An investigation by the OIG and FBI showed the former director had, over a 3-year period, written checks to various companies for fictitious services, forged signatures on the checks and deposited the funds to his personal accounts. He was convicted and sentenced to 3 years in a Federal prison (2 suspended), given a $1,000 fine and ordered to repay $53,000 to the home health agency.

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A patient complained that Medicare was being billed for psychiatric treatments she never received. As the result of an investigation by the OIG and Postal Inspectors the psychiatrist pled guilty and had to repay the carrier more than $23,000 prior to his sentencing.

STATE MEDICAID FRAUD CONTROL UNITS

Thirty-three States now have Medicaid Fraud Control Units (MFCUs) to handle Medicaid cases. For the last 6-month reporting period, MFCUs obtained over 180 convictions and about $2.1 million in fines and restitutions.

We are working closely with the National Association of Medicaid Fraud Control Units to identify training needs and to develop training programs to be used by all units. We have also developed and publicized several investigative targeting methodologies for MFCU use.

In addition to assisting MFCUs, we work with States not having MFCUs in anticipation of their certification application. We are currently processing applications for two States and have technically certified units for two States, whose State legislatures have not as yet officially budgeted the State match portion of their funding.

In addition to providing assistance, we conduct joint investigations with the MFCUs. At present there are six such efforts underway. One joint effort resulted because during our investigation of a doctor for Medicare fraud, we found the MFCU and a special inquiry judge were investigating the Medicaid and private insurance aspects of the case. After prosecution through the State courts for all three types of fraud, the doctor was sentenced to 120 days in jail and 3 years probation, fined $82,000 and ordered to restore more than $3,000. This is the first known conviction for Medicare fraud in a State court.

The California MFCU requested our assistance in an undercover investigation in a Southeast Asian community. Arrests and search warrants were issued for 34 physicians, pharmacists, acupuncturists and physician assistants. Sixteen persons accused of assisting in the fraud scheme were also arrested. The medical providers were accused of buying Medi-Cal (the California Medicaid program) stickers, billing and prescribing for patients not seen, and over-prescribing or dispensing drugs which would be sent to Southeast Asia.

CIVIL MONETARY PENALTIES

Our Civil Monetary Penalties Law (CMPL) is a powerful fraud deterrent as well as a major source of revenue. During this reporting period 18 civil monetary penalties settlements were made for a total of more than $2.1

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million, and savings are estimated at $270,000. At the time of this writing, we are investigating or negotiating about 27 other cases suitable for civil monetary penalties.

A number of individual CMP cases are of special interest or have significant recoveries. For instance, negotiations with a doctor who had been convicted of Medicaid fraud resulted in a $110,000 settlement. Four Pennsylvania anesthesiologists were charged with claiming hundreds of thousands of dollars for anesthesiology services which had actually been performed by nurse anesthetists. In a pre-trial diversion move they agreed to pay $381,000 in restitutions ($36,000 to the Medicare program and the remainder to the carrier). They also had to pay $70,000 in civil monetary penalties.

PROACTIVE PROJECTS

Several of our health care projects, including some recently initiated, have shown results during this period.

- The owners of a large pharmaceutical company have been indicted on charges related to defrauding Medicaid by failing to disclose the price they got for drugs sold directly to pharmacists, and by making cash kickbacks to hospital-based pharmacists.

- The first combined Medicare/Medicaid Task Force, established in Pennsylvania and consisting of OIG, FBI and MFCU agents, achieved two more indictments this period for kickbacks and false claims, for a total of eight convictions and four indictments since its inception. The two other, more-recently, formed Task Forces will probably show results next year.

- Project MEDPHODOC is designed to protect Medicare and Medicaid patients from persons with fraudulent medical credentials. The recent conviction of a man for selling false credentials from a Caribbean medical school has confirmed a real need for this project.

MIRS AND FRAUD ALERTS

Management Implications Reports (MIRs) are reports of management problems noticed during an investigation and referred for analysis and corrective action. The revised MIR system is proving to be another valuable proactive effort in the health care area. Of the 60 MIRs produced during this period, 11 related to health care. Two of these were translated into Fraud Alerts whereby information is distributed nationally to alert carriers to possible types of fraud.

- One MIR reported that a major company was charged with billing Medicare for more liquid oxygen than it actually delivered. The U.S. Attorney

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dismissed the indictment after determining the company had been using the same billing code for 5 years, assuming it to be correct since the carrier had never disallowed it or told them otherwise. To prevent similar situations, we issued a Fraud Alert to all Medicare carriers urging them to maintain detailed memoranda on all provider contacts.

- Another MIR reported that a storefront health clinic and a nearby shoe store had acted in collusion to charge Medicaid for orthopedic shoes while providing clients with low-quality everyday shoes. On the basis of the MIR, we published a Fraud Alert advising the States of the danger of this type of fraud and recommended specific regulations to prevent its occurrence.

Computer Applications

During the first 6 months of FY 1984, at least 50 computer matches and screening techniques have been used to spot problem areas in the Medicare and Medicaid programs. Highlights of several of these applications follow.

MEDICAID ENROLLEES IN HMOs

State Medicaid agencies have the option of contracting for voluntary enrollment of Medicaid clients in Health Maintenance Organizations (HMOs). Once the Medicaid agency enrolls a recipient in an HMO, no payment may be made to other providers for services which are offered by the HMO.

A computer application was developed to match, by date of service, all recipients' monthly premiums with fee-for-service payments to other providers for HMO-covered services. The application identified over 15,000 fee-for-service claims totaling approximately $600,000 paid for HMO enrollees. Recommendations called for the State to refund the $600,000 to the Medicaid program. Plans are underway to expand this match to other States.

ABORTION RELATED SERVICES

One State did not require independent laboratories to bill Medicaid using procedure codes that specifically identified abortion related laboratory tests. Through a computer program, we identified 92,119 independent laboratory claims involving $1 million for tests under certain procedure codes during the period June 1, 1980 through December 31, 1982. We selected a statistical sample of 200 of these laboratory claims and found 97 that were related to unallowable abortion related procedures. Based on this statistical sample, we estimated that at least $438,254 of unallowable laboratory tests were claimed by the State.

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DURABLE MEDICAL EQUIPMENT

Current Medicare rules provide that it is the beneficiary's decision to purchase or rent durable medical equipment. We developed a computer application designed to compare the aggregate of rental costs for each durable medical equipment (DME) item to the purchase price of that item. The results of this application indicated a Medicare savings of $1.7 million from purchase rather than rental of DME items.

If the same conditions exist nationwide, cost savings could be $50 to $100 million annually. Our review is continuing.

DUPLICATE PHYSICIAN/ LABORATORY CLAIMS

Carrier prepayment screens are normally designed to detect "exact" duplicates, that is, the same provider, same beneficiary, and same date of service. There are few screens to detect duplicate services rendered to a beneficiary on the same day (or for a range of days) by two or more different providers.

We designed a computer application to match one carrier's physician and laboratory claims files to identify two different providers (a physician and a laboratory) that billed for the same service on the same day or from one to three days apart on behalf of a beneficiary.

We identified over 5,100 potential matches where a maximum of $32,641 was overpaid for services rendered within one to three days apart. Additionally, one provider is being investigated. Our review is continuing.

IG Recommendations Not Yet Acted Upon

In the following areas, OIG recommendations included in previous reports to Congress involving significant dollar savings have still not been implemented.

SECOND SURGICAL OPINIONS

Studies on second surgical opinion programs (SSOPs) consistently point out that mandatory programs are effective in reducing unnecessary surgery. For example, one study showed mandatory programs covering just the more common procedures could reduce elective surgeries nationwide by as much as 29 percent in Medicaid and 18 percent in Medicare at annual cost savings of about $65 million and $135 million, respectively, using 1984 dollars.

We recommended that HCFA seek a legislative change to the Social Security Act that would require Medicare and Medicaid beneficiaries to seek a mandatory second surgical opinion for selected surgeries.

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HCFA agreed that there is evidence that a mandatory SSOP might reduce the amount of unnecessary surgery performed. HCFA believed, however, there were many unanswered questions in this area and contracted for an evaluation of the overall effects of a mandatory SSOP and the long-term savings from such a program.

MEDICARE ROUND DOWN

Based on a study at two carriers, we estimated Medicare Part B could save about $45 million annually or $225 million over a 5-year period if payments for odd-penny claims were rounded, on a per claim basis, to the next lower whole dollar.

The effect of such a policy on the individual beneficiaries or physicians/suppliers would be minimal—about 30 cents per paid claim. We proposed that HCFA seek authority to institute such a practice.

Legislation to implement this recommendation is under consideration in the Department and the Congress.

HOUSEKEEPING SERVICES

One State charged housekeeping services (e.g., shopping, ironing) for recipients to the Medicaid program without requiring that they be medically necessary by being linked to a "physician's plan of treatment." We found that this one State alone claimed $15 million over a 15-month period for such services. We estimate that, nationwide, improper claims could run as high as $30 million annually.

Although HCFA agreed to review the involved regulation, they have not, to date, taken action to correct this problem.

PSYCHIATRIC SERVICES

At a number of health facilities, we found psychiatric services were not limited to traditional treatment, but included a broad spectrum of services usually provided at an off-site location. Many of these services seemed of a social, recreational, or educational nature and thus suspect for reimbursement under Medicaid. The lack of clarity as to what constitutes "medically justifiable" services, coupled with the failure to define "billable encounters," in our opinion, results in significant abuses. At $54 authorized per patient visit, some $10 to $20 million annually could be involved nationwide.

Though HCFA initially agreed with us that Medicaid standards for outpatient psychiatric services were needed, they have not taken the necessary implementing action.

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SOCIAL SECURITY ADMINISTRATION

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CHAPTER III

SOCIAL SECURITY ADMINISTRATION

Social Security monthly cash benefits are paid to retired and disabled workers and their dependents, and to survivors of deceased workers from the Old Age, Survivors and Disability Insurance (OASDI) trust funds. The trust funds are financed largely by taxes on employees, employers and self-employed persons. The amount of payments is determined by the Social Security Administration (SSA). In addition to the OASDI programs, SSA administers five activities which are financed by general fund appropriations. These include the Supplemental Security Income (SSI), Aid to Families with Dependent Children (AFDC), Child Support Enforcement, Low Income Home Energy Assistance (LIHEAP), and Refugee and Entrant Assistance programs.

The amount of funds disbursed by SSA is enormous and increasing. SSA has the largest budget (about 65 percent) of all operating divisions in the Department. For 1984, SSA expects program expenditures to be $190 billion. This outlay is expected to increase by more than 6 percent in 1985 to about $203 billion.

OIG ACCOMPLISHMENTS

During the report period, the OIG focused a significant portion of its resources on reviewing SSA's payment processes and overall administration. We identified several areas where legislative or regulatory reform would result in substantial trust fund savings and improved program operations. We also identified several problem areas and the need for revised procedures or management improvements which, when implemented, would result in either an increase of trust fund receipts or a decrease in SSA expenditures. We recommended financial adjustments totaling $7.4 million. All programs in SSA have been given attention, but, due to the size of the disbursements, OASDI received primary focus.

This chapter is divided into: (1) legislative/regulatory reforms; (2) program administration; (3) investigative activities; (4) computer applications and (5) recommendations not yet acted upon.

Legislative/Regulatory Reforms

We identified potential savings of $375.8 million if our recommendations were fully implemented.

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OVERLAPPING SSI PAYMENTS

SSA has proposed legislation to eliminate duplicate benefits for individuals who receive SSI and retroactive OASDI benefits, and to eliminate the 2-month delay in counting income received from OASDI after SSI payments have already begun. Our review disclosed, however, two additional situations where overlapping payments are still being made costing Federal programs an estimated $30.5 million annually:

- Current legislation covers only duplicative payments received by individuals from the OASDI program. We believe this legislation should be expanded to include benefits received from other Federal programs such as veterans compensation and pensions, railroad retirement annuities and pensions, and worker's compensation.

- When an individual who is already receiving SSI begins to receive income from another source (whether from OASDI, other Federal benefit programs or wages), there is a 2-month delay in counting income being received. This delay of income recognition results in an overlapping payment for the first 2 months. We believe legislation should be introduced to count the first 2-months income in these situations.

Recommendations call for SSA to seek necessary corrective action including legislation if needed.

BANK MATCH

A computer match conducted by one State identified over 2,400 public assistance recipients who had bank resources in excess of applicable program limits. We estimate that bank matching by all States would produce first year savings of about $298 million and recurring savings of $161 million annually.

We recommended that SSA, the Health Care Financing Administration (Medicaid) and the Department of Agriculture (Food Stamps) cooperate in seeking legislation to require all States to conduct a one time computer match of this kind in fiscal year 1985 and recurring annual matches where such matches prove cost effective. SSA has asked for additional time in which to prepare their response to this report.

REPLACEMENT CARDS

At present, SSA assigns a Social Security number (SSN) and issues a SSN card at no charge to each SSN applicant. If the SSN card is lost or becomes mutilated or if information furnished SSA with the initial application changes (for example, name change), an individual may apply for a replacement card which SSA will issue, again at no charge. SSA issues approximate-

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ly 12 to 13 million SSN cards annually--about 5 million originals and 8 million replacements.

We estimate that SSA will incur costs of $46 million in 1984 to reissue free of charge about 6.5 million replacement SSN cards to individuals who have lost or misplaced their cards. In our opinion, replacing cards free of charge is not equitable since the majority of cardholders safeguard their cards. Additionally, we believe that a charge for replacement cards is consistent with OMB Circular A-25 regarding fee charges.

Our recommendations called for SSA to charge a fee for replacing a lost or misplaced card. We estimate about $46 million can be saved annually with the implementation of this recommendation.

LATE PAYMENTS TO SSA

A State may either supplement SSI benefits with monthly cash payments to recipients or enter into an agreement with the Secretary where SSA makes supplementary payments to recipients on the State's behalf. Currently, SSA makes supplemental payments on behalf of 27 States to SSI beneficiaries. These States must deposit the necessary funds with SSA for the monthly supplements on or before the date benefits are paid. There is no provision for interest or penalties in the event of late payment.

We examined the practices of States depositing funds with SSA for supplementation of SSI benefits. During FY 1983, SSA received $1.7 billion in such payments, some of which were frequently made late. These late payments have resulted in interest expense to the Treasury of $1.3 million per year.

We recommended that SSA take the necessary regulatory steps to implement procedures for assessing and collecting interest on late State supplementation payments. SSA said that it is not clear that the Federal Government loses interest as a result of present financial arrangements with the States. Further, if they were to charge interest the States might seek financial changes which could more than offset interest collected. SSA felt it would be most difficult to negotiate settlements with the States for prior fiscal periods if the IG's recommendation was implemented.

Program Administration

We reviewed the adequacy of internal controls, allowability of payments, eligibility of beneficiaries, efficiency of operations and other aspects of various SSA programs. Several of these reviews involved computer matches.

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We recommended financial adjustments of $7.4 million and numerous procedural changes in several SSA programs.

ENERGY ASSISTANCE

Our review in one State showed that over $1.3 million in Low Income Home Energy Assistance Program (LIHEAP) payments were made in payments to ineligible households; in overpayments to eligible households; or in improper emergency payments. We recommend a financial adjustment of more than $1.3 million be made. SSA is reviewing our recommended adjustment.

In another State, we noted that the State agency had requested and received $357,773 of Federal funds in excess of actual LIHEAP expenditures. The State agency agreed to return the $357,773 and to amend its procedures for requesting Federal funds.

DISABILITY CLAIMS

Over the past several years, SSA has taken numerous steps to speed-up processing of disability claims. One such action was the implementation of an expedited claims processing system which allows District Offices (DOs) to process claims in about one-third the time required by Program Service Centers (PSCs) or the Office of Disability Operations (ODO). Our review, however, disclosed SSA still requires that DOs forward to the ODO or the PSCs claims with conspicuous characteristics, such as blindness or trial work periods or involving the disability applicant's spouse and children.

SSA could save about $10 million annually if the disability claims now processed by SSA's ODO and the PSCs were processed by the DOs. Additionally, DOs would be able to improve service to the public by processing claims an average of 36 days faster than it now takes ODO. Our report, which is with SSA for comment, recommends that SSA allow the DOs to process these cases.

DISABILITY TERMINATIONS

We reviewed the efficiency of the SSA disability termination process following an Office of Hearings and Appeals (OHA) termination decision. We found that SSA fails to take timely termination action and that the failure resulted in total overpayments of $28 million from 1982 and 1983 cessation decisions.

We are recommending that SSA (1) emphasize the need to follow existing termination instructions and (2) utilize OHA records to detect additional cases. If appropriate corrective action is taken, we project a savings of $67 million in 1984.

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COMPUTER SECURITY

There are six SSA centers throughout the United States which process post entitlement actions, claims and payment tapes. OIG reviewed the security of one center's computer room and library and also whether a contingency plan was in place at the PSC to minimize the effects of a disaster, for example, a fire or flood. We found better controls were needed over access to the computer room and computer files. Additionally, the center did not have a complete contingency plan. A number of recommendations were made to SSA to correct these deficiencies.

EXCESS EQUIPMENT

During FY 1982, SSA spent approximately $113 million for purchases of electronic data processing equipment, supplies, and services. We found several problems relating to excess EDP equipment: (1) payments of $355,000, covering a 3-year period, were made for maintenance and rental of equipment which had been declared excess and removed from service; (2) inventories on equipment awaiting disposal were incomplete or inaccurate; and (3) excess equipment was being stored for excessively long periods of time adding unnecessary costs for space rental. Appropriate recommendations were made to correct these weaknesses.

EXCLUSIONS SAMPLE

We examined SSA's review of quality control sample cases in which the beneficiary cannot be located in order to determine if an ongoing review of such cases would provide a systematic means of detecting employee fraud.

We found there was inadequate resolution of excluded cases, some of which involved suspicious circumstances and substantial overpayments. We also found SSA's process for paying SSI benefits on unverified SSN's has resulted in the accumulation of over 60,000 unverified SSNs and that some cases involving incorrect payments are the direct result of incorrect SSNs.

We are recommending that SSA: (1) strengthen the process for resolving excluded cases; (2) emphasize the need to refer certain excluded cases for fraud investigation; and (3) check all unverified SSNs currently accumulated. We expect substantial savings to result from these corrective actions.

SSI CASH REFUNDS

As a supplement to the findings of an earlier OIG study indicating losses of $26 million, we reviewed inactive files on the Supplemental Security Record to determine if additional losses were indicated by the existence of unverified SSI cash refunds. Such a refund exists when an SSA field office input of refund information is posted to the SSI record but not substantiated by the responsible headquarters office.

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We found that about $6 million was lost due to administrative errors resulting in single refunds being given double credit, the unavailability of data needed to trace missing refunds, and/or suspected thefts of refunds.

We recommended that SSA (1) resolve the existing unverified cash refunds and (2) develop an ongoing reconciliation process. These recommendations would result in savings of almost $6 million and would surface previously undetected thefts for criminal investigation.

RETURNED CHECKS

An unverified check occurs when SSA records of that returned check are not verified by Treasury receipt. Our study of the existence of large numbers of unverified returned checks in SSA's Title XVI program revealed: (1) administrative errors allowing single returned checks to be given double credit (projections indicate a loss of almost $4 million); (2) the erroneous annotations that the check was returned when it was not returned ($230,000); and (3) a processing anomaly caused by the nearly simultaneous processing of non-receipt allegations and returned checks resulting in the issuance of duplicate payments ($70,000).

We recommended that SSA: (1) resolve the existing unverified returned check problem; (2) develop an ongoing reconciliation process; and (3) modify existing receipt procedures in SSA field offices. The proposed actions would result in savings of over $4 million for prior years and $400,000 for the year following implementation.

FIELD REMITTANCE PROCESS

We visited four offices in the Atlanta region to evaluate the potential effectiveness of the eight models of a revised field remittance process designed by SSA to prevent thefts or insure their early detection. Although the model processes contained improved internal control features, we found significant weaknesses in the models that left the remittance process vulnerable to fraud.

We recommended that SSA: (1) introduce sophisticated remittance control equipment into the SSA field office remittance process; (2) bring remittances under control immediately upon receipt in the field office; (3) restrict the availability and use of temporary receipts; (4) develop a systems-based control over the field office remittance process; and (5) establish a procedure to verify that returned Title II checks are cancelled by Treasury and posted to SSA records.

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CONFIDENTIALITY OF MEDICAL RECORDS

We reviewed SSA's policy and procedures pertaining to the confidentiality of medical records to determine if adequate safeguards are in place. State Disability Determination Sections are required to notify all newly recruited consulting physicians of the confidentiality rules in effect. However, physicians are not required to acknowledge receipt and understanding of such instructions. To rectify this situation, we proposed that SSA require all consulting physicians to sign and date a statement acknowledging their receipt and their understanding of instructions regarding the confidentiality of all social security records. SSA agreed to require such statements prospectively.

REVIEW SPECIALIST TRAVEL

We reviewed travel procedures used by SSA's Quality Review Specialists to determine if controls are in place to detect and prevent fraud. While the HHS Travel Handbook provides adequate guidelines for the examination of travel vouchers, SSA has generally supplemented these guidelines for special situations. However, despite a constant high level of travel for these specialists there is an absence of specific procedural guidelines for the preparation and review of detailed travel itineraries routinely required. Furthermore, there are no national procedures for periodic sample reviews of the travel vouchers.

We recommended that the SSA Travel Handbook be revised to provide detailed procedures for the Quality Review Specialist travel and that there should be a sample review of such procedures and the appropriateness of the travel expenditures. SSA has agreed to produce a special guide to tighten these procedures and to improve managers' oversight to travel.

Investigative Activities

Social Security fraud accounts for the largest number of OIG convictions. During this period, investigations of Social Security fraud resulted in 317 convictions and 4 civil judgments and settlements. These investigations also resulted in $1.8 million in fines, restitutions and settlements; and $3.4 million in recoveries, a savings of $1.5 million. An additional 80 AFDC convictions and almost $1 million in recoveries were the result of joint investigations with State agencies.

MASS SSA ACTIONS

The amount of money involved in a Social Security case, however, coupled with the fact that the perpetrator is usually not a newsworthy individual, makes prosecution and the resulting monetary and deterrent value difficult to obtain. Mass prosecution actions, therefore, continue to be effective in

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eliminating these disadvantages. Over the past year all but one of the mass actions taken in our cases were related to Social Security cases.

COOPERATIVE PROJECTS

We have nine other projects aimed at identifying welfare and disability fraud in several States. These matches are expected to proliferate because welfare and disability benefits programs differ among the States and are administered by a variety of agencies. These projects generally require a cooperative effort with other agencies since the persons involved are usually receiving multiple benefits.

AFDC STATE BENEFITS PROJECT

After achieving marked success in a California experiment, the AFDC project is aimed at finding and prosecuting persons who have concealed receipt of Social Security or Supplemental Security Incomes while applying for or receiving welfare benefits from State or county agencies. The OIG, Office of Investigation has set up a system with SSA whereby prosecutors needing official SSA documents could obtain them in record time to try welfare cases. This project has now mushroomed. During this reporting period alone, 80 convictions, over $554,000 in fines and restitutions, and $395,000 in civil recoveries have been obtained. Since the inception of this project there have been 179 convictions, $721,000 in fines and restitutions and $476,000 in civil recoveries.

FALSE IDENTIFICATION

Over the past few years we have become deeply concerned with fraud involving false identities, because these cases quite often involve Social Security numbers (SSNs). SSN projects require cooperative efforts with other agencies because of the variety of authorities and schemes involved. For example, one such incident involved a Georgia couple who had used 20 different Social Security numbers to establish aliases to set up phony businesses and a bank account to obtain more than $200,000 in "dial-a-loan" transactions from the Chase Manhattan Bank. They were found guilty of mail, wire, and credit card fraud and drug violations. Computer matches to detect SSN problems are described in the next section of this chapter.

SSA EMPLOYEE FRAUD

Because of their access to records and ability to influence the system processes, SSA employees may become involved in fraudulent identification schemes. For example, an SSA service representative in Chicago was caught accepting money to process Social Security cards for illegal aliens. A claims representative in Texas set up 24 fictitious beneficiary files to obtain more than $300,000 in fraudulent benefit payments. A data review technician in New York generated false SSA claims for members of her family and friends, dividing at least $50,000 among the scheme participants.

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MIRS AND FRAUD ALERTS

Since SSA employees are the first line of defense against fraud in SSA programs, we have helped design training programs to show these employees how to recognize attempts at fraud. Based on problems we have uncovered, we also recently issued a Management Implications Report (MIR) and a Fraud Alert which cautioned SSA employees to watch for false birth certificates presented by certain refugees from Southeast Asia.

PROJECT PAYBACK

In December 1983, the OIG established a national project to recover incorrect payments in Social Security matters that involved suspected fraud but did not meet prosecutive criteria. The incorrect payments are brought to OIG attention by SSA personnel who discover them when processing claims, by matches of SSA payment records against records of other benefits or events, or by tips from informants. When a significant amount of money is involved, the OIG sends a demand letter stating its involvement in the matter, the amount of incorrect payment, language to motivate the incorrectly paid person to make refund, and the office to which to make the refund. In the short time this project has been in effect, we have reported recoveries of more than $300,000 and savings of over $6,000.

Computer Applications

COMPUTER DETECTION

Although we must continue to count heavily on individual allegations for uncovering Social Security fraud, we have found that projects designed to identify potential fraud are highly productive, especially projects using computer techniques. We are now making a concerted effort to specially code criminal cases related to SSA projects to enable us to better evaluate their impact. Some of the more significant matches are described below.

PA/WAGE DATA

We reviewed the use by three State agencies of State wage data to help determine eligibility for public assistance (PA). One State compared wage data to PA data but did not provide adequate guidance to caseworkers on the use of match results. Thirty-eight of forty-six PA recipient files we reviewed in this State showed income which had not been reported on PA application forms. Thirty-three of these cases have been referred for investigation. We estimate that $1.3 million could be saved on an annual basis.

In the second State, the data was not used effectively, and we estimate that more than $627,000 of unallowable AFDC benefits were paid. Actual amounts may be higher when benefits automatically received under other programs are considered.

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In the third State, PA recipients in 50 of 102 cases reviewed had failed to accurately report their income. Nine other cases were suspect, but employers refused to supply detailed wage data for use in the review. The 59 cases were referred for criminal investigation. Projecting the results of this review, we estimate that more than $3.6 million may have been overpaid to AFDC recipients in this State in 1982.

SSA/RRB DEATH MATCH

A computer match of the Railroad Retirement Board (RRB) death records from 1973 through June 1982 against SSA's Title II Master Beneficiary Record identified 1,046 "raw hits" (i.e., cases where SSA records apparently did not reflect the beneficiary's death). Analysis of these cases revealed that in 75 cases, beneficiaries had been overpaid $652,000 by SSA. In an additional 685 cases, SSA had incorrectly certified benefit payments of $4.9 million to the RRB. We estimate that because of our matching efforts SSA will avoid future issuance or certification of $2.1 million annually. Our work is continuing.

SSI/DEATH MATCH

We ran a computer match of one State's death records against the SSI State Data Exchange files for that State. The match disclosed 169 cases involving over $140,000 in SSI payments made after the person's death. Eighty of these cases involved the concurrent payment of OASDI benefits of almost $53,000 after the date of death. Information on all cases is being evaluated to determine if any fraudulent activities occurred. Work is now underway by SSA to contact all States to obtain their cooperation in furnishing accurate and timely death information.

FEDERAL EMPLOYEES/BLACK LUNG MATCH

A computer match was designed to identify Federal employees who received SSA Black Lung benefits while employed by the Government. We found 11 Federal employees who received improper benefits totaling $60,000. These cases have been referred for criminal investigation.

ILLEGAL ALIEN MATCHES

Three years ago we undertook a project with Immigration and Naturalization Service to find fraudulent use of SSNs by illegal aliens to obtain jobs and benefits. Special computer programs were developed, and the resulting information was made available to other law enforcement agencies. This project has now become a routine operation. However, its early results became the basis for creating other projects to target instances of false identifications.

In one of the newest of these projects being developed, "Project SSNAP-BACK," we received 35,000 SSN cards confiscated from illegal aliens, as well as 50,000 arrest reports for illegal aliens. From the results of two pilot

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runs, we expect recoveries could average $10 million to $20 million annually.

OTHER FALSE ID MATCHES

Three more projects initiated during this period cooperative efforts to find other types of false identification schemes.

- "Project Pilots" is a joint project with the Department of Transportation to match airplane pilot certification tapes against SSA's SSN numident files and death records. In addition to identifying SSN abuse, this project will identify unqualified or incompetent pilots.

- "Project VAGA" is a joint project with the VA to identify veteran beneficiaries who have remarried or are working under other names to avoid reduction or elimination of benefits.

- An interagency project is working to identify aliens who are defrauding the credit industry through false identification documents to obtain credit cards or advances in credit.

Recommendations Not Yet Acted Upon

In the following areas OIG recommendations included in previous IG reports to Congress involving significant dollar savings have still not been implemented.

FICA DEPOSITS

The Inspector General's Semiannual Report for the period ended September 30, 1983 noted that Congress passed legislation mandating a semimonthly deposit schedule of Social Security contributions made by States on behalf of State and local employers. Social Security contributions made by the States total about $19 billion annually. The semimonthly schedule, effective January 1984, will increase Trust Fund interest income and contribution receipts over the next 5 years by $496 million and $836 million, respectively.

Our final report on State deposit schedules, recommended a further legislative change requiring State and local government employers to follow the private sector schedule. Requiring individual employers to deposit on the private sector schedule directly with IRS would provide the flexibility in deposit timing which is needed by smaller employers. It would also accelerate the deposits of larger employers who generally can meet tight time deadlines.

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The semimonthly schedule requires States to make single consolidated deposits for all covered employers twice each month. To meet this requirement, individual employers are generally allowed about one week after a biweekly payday to get their deposits to the State for consolidation.

Smaller employers, who constitute about 35 percent of those reporting, are generally not capable of meeting such a time frame. Without a flexible deposit schedule that recognizes their processing limitations, noncompliance could be expected to become a significant problem.

Acceleration of State deposits resulting from adoption of the private sector schedule would further increase Trust Fund interest income and contribution receipts over 5 years by $480 million and $988 million, respectively. To encourage compliance with accelerated deposit requirements, our report also recommends that the 6 percent interest rate charged on late State Social Security deposits be increased commensurate with the market level rates currently charged on late private sector deposits.

Legislation to implement these proposals is under consideration in the Department.

UNCASHED CHECKS

The Inspector General's 1980 Annual Report noted that States were not crediting Federal programs for their portion of uncashed AFDC benefit checks and other collections. Some of $30 million were identified as due the Federal Government. During 1981, we identified another $9 million due Federal programs.

We recommended SSA require timely return of the Federal portion of uncashed AFDC benefit checks and other credits. The proposed new rules were initially delayed for a review of all proposed new Federal regulations. SSA now informs us that these regulations, requiring the return of the Federal portion of these checks after 180 days, should be issued by mid 1984.

AFDC/HUD SHELTER ALLOWANCE

An estimated one million AFDC recipients in 41 States live in housing subsidized by the Department of Housing and Urban Development or a State agency also receive a shelter allowance in their monthly AFDC benefit payment. As a result, we believe $377 million in duplicative shelter benefits are being provided each year. We recommended that SSA seek a legislative amendment to require all States to consider these allowances in determining AFDC assistance payments.

We continue to recommend that the Department seek legislation to require all States to consider shelter allowances in determining AFDC assistance payments.

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GRANTS AND INTERNAL SYSTEMS

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CHAPTER IV

GRANTS AND INTERNAL SYSTEMS

This chapter concerns OIG activities designed to assist managers in improving overall efficiency and effectiveness of internal Departmental management of the Public Health Service (PHS), the Office of Human Development Services (OHDS), and the Office of the Secretary (OS). Although the dollars involved in these areas are substantially less than those in programs administered by the Social Security Administration (SSA), and the Health Care Financing Administration (HCFA), the amounts are still quite substantial. For FY 1984, approximately $8.6 billion will be spent by PHS, $6 billion by OHDS and $246 million for Departmental management by OS. Also, over 86 percent of the Department's discretionary expenditures are made in these areas.

The potential vulnerability of grants and internal systems activities to fraud, waste and abuse is magnified by the:

- Wide variety and large number of programs. PHS operates about 68 major programs ranging from biomedical research support to health resources and services financing. The 29 major programs in OHDS include assistance to the elderly, the disadvantaged and the handicapped. The Department uses grants, contracts, cooperative agreements, loans, and loan guarantees to fund these programs.

- Thousands of grantees and contractors funded by the Department including State and local governments; Indian tribal governments; public and private nonprofit organizations; and individuals. Funding ranges from millions of dollars to much smaller awards.

- Complexity of the Department's administrative structures. The Department operates through headquarters offices in Washington, D.C.; Baltimore, Maryland; and ten regional offices employing about 137,000 persons. Department officials use computer-based accounting, grants/procurements, cash management, payroll systems and other management systems in these operations.

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OIG ACCOMPLISHMENTS

During this reporting period, we identified opportunities for cost savings ($33 million) through increased efficiency in program operations and management. The OIG also actively participated in Governmentwide projects sponsored by the President's Council on Integrity and Efficiency (PCIE) and the Administration's Reform '88 initiatives. From October 1, 1983 through March 31, 1984, we recommended financial adjustments of $47.3 million. More importantly, we surfaced significant management weaknesses in computer security, Federal contracting, and cash management. Questioned costs by operating and staff divisions were:

	PHS	OHDS	DEPT ADMIN
(in Millions)	$5.2	$40.9	$1.2

This chapter is divided into sections dealing with PHS, OHDS, and the OS. Specific OIG emphasis was placed on: (1) grant/contract administration; (2) adequacy of internal controls; (3) debt collection; (4) cash management; (5) procurement administration; and (6) investigative activities.

Public Health Service

PHS will spend an estimated $8.6 billion in FY 1984 on health research, prevention of disease and other activities which generally support improvement of public health. Our reviews during this period surfaced opportunities to more efficiently administer grants, contracts, and loan programs by strengthening internal controls and program management. In addition, we identified questionable costs of $5.2 million.

CONSTRUCTION FUNDS

In October 1982, we pointed out that as much as $80 million might be recovered from medical facilities that received construction grants under the Hill-Burton program but that have subsequently failed to continue to meet program requirements. As a result, PHS sought legislative authority to improve the Department's ability to make recoveries.

We believe that this legislative effort should be expanded to strengthen recovery provisions for other health programs having requirements similar to Hill-Burton. We identified three such PHS programs: Health Professions Teaching Facilities (HPTF), Nursing Training Facilities (NTF), and Community Mental Health Centers (CMHC). Under these programs, $1.7 billion had been awarded to 2,243 grantees over the years.

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Program officials told us that few required recoveries have been identified for the HPTF and NTF programs. However, should the Hill-Burton experience apply to these programs, an additional $20 million could also require collection. With respect to CMHCs, should 10 to 30 percent of these fail, an estimated $20 to $62 million could also become due for collection.

Program officials agreed that the proposed Hill-Burton legislative changes should also apply to these programs. Accordingly, PHS and the Office of General Counsel took prompt action to include these program changes in the Department's FY 1985 legislative proposals.

PROGRAM INFORMATION SYSTEM

PHS' National Institute of Neurological and Communicative Disorders and Stroke (NINCDS) awarded three contracts totaling $1.2 million for the development of a comprehensive program information system referred to as "PINS." In-house costs of $800,000 were also incurred.

After 7½ years and a cost of $2 million, the project was abandoned without the system becoming operational. We found that the system was not successfully implemented because specifications were out of date and incomplete; efforts to obtain technical advice were not documented; deliverables were not adequately reviewed; the development plan was not followed; and computer resources were inadequate.

Our recommendations called for PHS to take action to prevent such occurrences in other system developments. In FY 1984, PHS plans to spend $8 to $10 million on development of such systems. The Deputy Assistant Secretary for Health Operations generally agreed with our findings and recommendations and advised us that corrective actions were being taken.

IHS COMPUTER SECURITY

We evaluated the security and protection of data, equipment, and facilities at the Indian Health Service (IHS), Data Processing Service Center, Albuquerque, New Mexico. The Center provides data to the U. S. Treasury so that payments can be made to health care providers servicing approximately 500,000 IHS beneficiaries. We found that: (1) elements of essential documentation such as cost benefit studies, risk analysis, system and programming manuals were missing; (2) back-up and recovery plans had not been developed; (3) duties were not adequately separated for some programming tasks; (4) use of passwords was not effective; and (5) required background screenings of employees had not been performed. Appropriate recommendations were made to correct these deficiencies. PHS concurred and has taken action to correct noted weaknesses.

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DRUGS AND MEDICAL SUPPLIES

PHS spends about $122 million annually on a wide variety of drugs and medical supplies. The bulk of the purchases are made by the National Institutes of Health (NIH) and the Indian Health Service (IHS) on the open market or from several Federal Government sources.

We compared prices for items in a random sample of 200 medical purchase orders each at NIH and IHS, comprising 913 drugs and medical supply items totaling nearly $215,000. We found that the cost of 230 items could have been reduced by over $22,000 if generic drugs and more economical sources had been more extensively used. If the total annual PHS procurement of drugs and medical supplies of $122 million were reduced by the test's savings percentage (10.5 percent), annual savings for PHS could amount to almost $13 million.

Most of the estimated savings would result from further use of the Department of Defense supply system which often provides supplies at the lowest cost. Savings would also be available if PHS better assured that generic drugs were purchased when appropriate.

Office of Human Development Services

In FY 1984, OHDS will spend $6 billion to provide a variety of social services to American children, youth and families, older Americans, native Americans, and the Nation's disabled. Our reviews during this period identified $40.9 million in questionable expenditures to ineligible recipients and unallowable program administrative costs. We also focused on identifying opportunities to operate selected programs more efficiently and to achieve program objectives more effectively.

FOSTER CARE

Enactment of Title XX of the Social Security Act, effective October 1, 1975, amended the AFDC Foster Care program to exclude social services costs from Federal financial participation. OIG found that contrary to statutory provisions, one State claimed $34.5 million in Federal funds for (1) social services provided to children in foster care family boarding homes and to their families (such costs were to have been claimed under Title XX and subject to a ceiling) and (2) for staff and other placement activities for private, nonprofit child care and placement agencies (Federal payment of these costs were prohibited under any legislation).

Our recommendations called for a financial adjustment of $34.5 million. While the State did not agree with our recommendations, OHDS officials concurred with our position.

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TITLE XX

From October 1, 1975 through September 30, 1981, one State used Federal funds of $70.5 million to purchase Title XX services. OIG found that about $9.3 million was not allowable under the Title XX program:

- $5.6 million was for operating and maintaining juvenile detention centers. Basic costs at these centers for food, clothing, shelter and so forth are not eligible for reimbursement under Title XX.

- $2.2 million was for overclaimed indirect costs. These overclaims resulted from incorrect costs rates, computational errors, and errors in classifying costs.

- $1.0 million was for intensive psychiatric services provided to youths in a State mental hospital. These services were not specifically described in the State's Annual Plan or were provided by a facility other than the one in which the youths were confined as required by Title XX.

- $500,000 was for routine room and board costs. The costs of such custodial care are not allowable under Title XX.

Recommendations call for a financial adjustment of $9.3 million and certain procedural changes. The Regional Administrator, OHDS, has concurred in all findings and recommendations.

HEAD START PROGRAM ADMINISTRATION

The Head Start program provides comprehensive support and early childhood development services for poor children up to age five. During 1984, approximately 429,000 Head Start children will be provided day care services, nutrition, education, and health related and other social services. Emphasis is also being placed on special services to handicapped children and on improving parenting skills. In FY 1984, about $1 billion in Federal funds will be spent on the program.

HEAD START AUDITS

Audits of Head Start program grants are made by non-Federal auditors. Each non-Federal report is reviewed by OIG for matters requiring immediate action (possible fraud or abuse), conformance to established Federal guidelines, and findings requiring action by the Department before being issued to the Office of Human Development Services (OHDS). During this period, we evaluated 514 reports which recommended adjustments of $5.7 million in costs charged to the program. These reports also cited over 561 deficiencies in grant administration such as problems with accounting, internal controls and record-keeping practices.

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HEAD START TRAINING AND TECHNICAL ASSISTANCE

We also surveyed Head Start program operations to determine why this program continued to need substantial Federal funds for training and technical assistance (T&TA). We found: (1) the yearly funding of $25 million for training and technical assistance actually constitutes seed money; (2) funding for T&TA as a portion of the total Head Start appropriations has decreased from 9.6 percent in 1966 to 2.6 percent in 1984; (3) ongoing training is consistent with the Head Start mission; and (4) OHDS has no system for assessing the impact of T&TA expenditures and no study has been done.

We recommended that OHDS ensure that (1) T&TA funds are being used effectively and for the purpose intended and (2) sufficient guidance and support is available to programs in expending T&TA monies and in obtaining needed services. OHDS officials concurred with our recommendations.

DEVELOPMENTALLY DISABLED YOUNG ADULTS

We conducted a study of the transition by developmentally disabled (DD) young adults from school to adult services and of program models which have successfully dealt with this transition. The study found that: (1) this transition is an emerging issue in many parts of the country; (2) there is little case management or coordination of services after DD young adults leave school; and (3) there are serious gaps in DD adult services.

We recommended that the Department, in concert with the Presidential initiative in this area, expand employment opportunities for the DD adult population. OHDS agreed with this recommendation and was already mobilizing existing networks, enlisting private sector support, and including employment practices in DD discretionary grants. These actions will create 25,000 jobs for DD young adults, saving the Federal Government $126 million per year and State and local government $74 million per year, for a total of $200 million per year. We are currently working with OHDS, HCFA, and SSA on our additional recommendations to increase community integration of DD young adults and to begin interdepartmental activities with the Departments of Labor and Education.

RUNAWAY AND HOMELESS YOUTH

We studied the Runaway and Homeless Youth Program to estimate the number and types of runaway and homeless youth nationally, assess un-met needs and recommended ways to target available funding better. We found that: (1) there are at least 558,000 "official" runaway and homeless youth in the U.S., and that estimates of one million are not unrealistic; (2) these youths need emergency shelter, counseling, and longer term placement; (3) the national voluntary reporting system has serious deficiencies; and (4) the National Runaway Switchboard is plagued with problems.

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We recommended that OHDS improve the voluntary data collection system, validate the data received, and disseminate the information nationally. We also recommended that technical improvements be made to the Switchboard and that coordination efforts be undertaken with the private National Runaway Hotline. These improvements could double the accessibility of this $300,000 service.

Departmental Management

The Office of the Secretary (OS) will spend about $246 million in FY 1984 to provide executive leadership and direction for Department activities and to provide common services such as accounting and payroll to Department operating divisions. OIG emphasis was placed on strengthening Department internal controls and other mechanisms to prevent, as well as detect, management inefficiency.

INTERNAL CONTROLS

We reviewed the Department's efforts to establish and maintain effective internal administrative and accounting control systems required by the Federal Manager's Financial Integrity Act and OMB Circular A-123. The Department took early and aggressive action to implement these Federal requirements. However, we noted several areas requiring attention:

- The scope and documentation for many reviews as well as ongoing efforts substituted for formal reviews were inadequate;
- The inventory of activities subject to internal control reviews omitted many programmatic areas; and
- Procedures for conducting internal control reviews differed from those advocated by OMB guidelines.

Recommendations were made and the Department is now developing modifications to correct these weaknesses.

INSTITUTIONS OF HIGHER EDUCATION

To enable us to more effectively carry out our audit responsibilities with the resources available, we are continuing to pursue our 1981 initiative to implement a single Governmentwide approach to the audit of institutions of higher learning. For this purpose, we have prepared revised draft audit guidelines which have been submitted to an interagency committee chaired by OMB for approval.

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In the interim, we are contacting all major institutions receiving Federal research, training and development funds to strongly encourage an audit of Federal activities during the year ending 1984. Such audits will demonstrate whether institutions have controls in place to ensure proper accountability over Federal funds received.

We are also providing up front technical assistance including: (1) a single audit seminar currently being presented by the Association of Government Accountants; (2) an audit standards awareness course; (3) a training course in all aspects of the single audit; and (4) a plan in conjunction with OMB for the orderly allocation of audit cognizant assignments for State and local governments.

We also continue, to the extent that audit resources are available, performing reviews of specific audit areas identified by the various Federal agencies. During this reporting period, 185 reports were issued on research, development, and training activities at institutions of higher education. The reports recommended recovery of $300,000.

BLOCK GRANTS

Block grants continue to constitute a key element of the Administration's Federalism program. For FY 1984, the Department funded seven block grants totaling $6.2 billion. Legislation for four of the seven block grants—Low Income Home Energy Assistance; Preventive Health and Health Services; Alcohol, Drug Abuse and Mental Health (ADAMH); and the Primary Care Block Grant—expires at the end of FY 1984 requiring congressional reauthorization to refund the grant programs beyond the present fiscal year.

In carrying out our monitoring responsibilities in the area of block grants, we have completed our second survey of State plans for auditing block grants. We found that all States are, or will be, conducting audits that cover some portion of their FY 1982 expenditures.

Two audits of block grants disclosed serious cash management and internal control deficiencies.

A non-Federal audit of one State's expenditure of FY 1982 funds noted draw-downs of Federal funds, totaling $2.5 million in excess of program expenditures. Also, $55,000 of salaries and fringe benefits were questioned because certain employees were not listed as program employees or were not working in the block grant area. Recommendations call for the establishment of procedures to provide for the matching of draw-downs with the pattern of disbursements.

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More seriously, internal control weaknesses were found at the major sub-recipient of the ADAMH block grant. The State is now investigating instances found of falsification of records and misappropriation of funds. Accordingly, the non-Federal auditor has questioned costs of all FY 82 purchases ($314,000) made by this sub-recipient.

UNLIQUIDATED OBLIGATION BALANCES

Appropriations with specific time limits expire for obligation purposes at the end of the period designated. The obligated balances are retained by the agency and remain available indefinitely for disbursement of valid claims against obligations which were incurred during the years of availability. Two years after an appropriation account expires, it is closed and merged into a "M" account which holds all previously expired balances of appropriations for the same general purpose. The successor account identity is the same as the merged appropriation with one exception—a letter "M" is substituted for the numeric year designator.

We tested selected unliquidated obligation (ULO) balances in various "M" accounts maintained by the Assistant Secretary for Management and Budget's Division of Accounting Operations (DAO) for the Office of the Secretary (OS) and OHDS. As of April 1983, $97.1 million was recorded in the "M" accounts.

Although DAO policies for maintaining account balances generally conformed with Federal and Department directives, we found the policies were not always followed. Performance of periodic reviews was left to the discretion of accounting technicians and written procedures were not prepared to guide accounting supervisors and technicians in performing, documenting or monitoring reviews. As a result, few balances were reviewed and validated. About $11.9 million of the $12.3 million of balances examined could have been liquidated or deobligated by DAO from documentation which we found readily available in DAO files or which was due from program, procurement or grantee officials. We believe that improved review practices could possibly result in liquidating as much as $90 million of the balances in DAO "M" accounts.

CASH MANAGEMENT

Monitoring of cash advances is especially significant since the Department annually advances about $100 billion to over 9,000 entities. Some of our more significant findings:

- One medical college accumulated funds totaling about $729,000 in a loan account. Of this total, $197,000 was transferred to an operating account, used for non-program purposes and not repaid. These excess

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funds cost the Federal Treasury $316,000 in unnecessary interest expense.

- A university invested cash from operating PHS student loan funds in various short term securities earning interest of $328,000. The institution did not credit appropriate Federal programs for any of this interest.

DEBT COLLECTION

For the 6-month period ended December 31, 1983, debts due the Department decreased $410 million, collections decreased $17 million and write-offs of accounts receivable increased $353 million. The increase of write-offs represents a one-time adjustment for unrecoverable SSI overpayments to beneficiaries.

On a cyclical basis, the OIG monitors the Department's debt collection activities performed by the Division of Accounting Operations (DAO). For this period, we examined the debt collection activities of OS and OHDS. Our review of the OHDS collection activities showed that the OHDS' status report to Treasury on debt owed for September 30, 1983 was understated by $36.2 million due largely to audit disallowances under the Title XX program. This occurred mainly because DAO did not follow Departmental guidelines and record non-cash recoveries from sustained audit disallowances—such as financial adjustments and offsets to future grants/awards—as accounts receivables.

We recommended that DAO establish controls and procedures to preclude the recurrence of such omissions. OHDS officials agreed to review the audit disallowances and determine which are recoverable. The Department advised us that DAO has put controls in place to assure that all future audit disallowances are properly accounted for.

In addition, we found that DAO needed a formalized system to readily provide for the aging of audit disallowance receivables. The aging of receivables was based on internal DAO estimates.

AUDIT RESOLUTION

There are currently seven reports with monetary findings totaling $2.9 million that have not been resolved within the 6-month time frame mandated by law. These reports are with the following OPDIVS for resolution.

	PHS	SSA
REPORTS	4	3
MONETARY FINDINGS	$1,957,467	$1,010,399

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The OIG is closely monitoring this situation to make sure these audits are resolved promptly.

Investigative Activities

There have been fewer allegations of fraud reported for contractors and grantees than for Social Security beneficiaries or Medicare providers and beneficiaries. Also these organizations and individuals are subject to scrutiny before they are allowed to handle Department programs or funds. As a result, contractor, grantee and employee fraud cases comprise the smallest portion of our investigative workload. OIG investigations of GIS matters resulted in 21 convictions. Investigative efforts also resulted in fines and restitutions of $36,000 and recoveries of $281,000. The following cases, however, are examples of the substantial fraud we have found.

- The director of an agency of New York's community action program was found guilty of falsely obtaining more than $42,000 in SSA payments, housing subsidies and federally funded salary.

- An IHS dental clinic technician had caused a check from a gold refining company for more than $6,000 to be made out to him personally rather than to the clinic as payment for scrap gold. He pled guilty to embezzlement.

- The accountants of a Brooklyn health care center were found guilty of embezzling PHS funds, and Medicare and Medicaid payments.

EMPLOYEE FRAUD

In March, we accompanied IRS agents in an on-the-job arrest of a computer operations supervisor at HHS headquarters for income tax fraud. At least 11 persons have been implicated in the scheme, and we are also investigating the employee for SSA beneficiary fraud. In this case, as in other employee cases, Department components are urged to take immediate administrative action.

Computer Applications

Computer matches and screening techniques are used to spot problem areas in Departmental programs and operations. Highlights of one such application follow.

DEPARTMENT PHYSICIANS

To enhance the recruitment and retention of highly qualified physicians in the Department, physicians are paid special pay in addition to other pay and

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benefits. Physicians and dentists on active duty in the Public Health Service (PHS) Commissioned Corps are authorized special pay by Section 805 of the Mental Health Systems Act of 1980 (Public Law 96-398). This special pay is in addition to regular pay and is a means of recruiting and retaining qualified physicians.

We developed several computer applications to determine if Department physicians receiving special pay (1) improperly received fees for services rendered as consultants or principal investigators on Department grants and contracts and/or (2) separated from the Department prior to their contract completion date without appropriate pay adjustments. As a result of these applications, four physicians were identified as being either consultants or principal investigators. One consultant received $78,000 over the last five years. In addition, seven physicians were identified who either separated prior to their completion date and/or were overpaid and as a result owe the Department over $35,000. Our review is continuing.

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LEGISLATIVE AND REGULATORY REVIEW

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CHAPTER V

LEGISLATIVE AND REGULATORY REVIEW

PREVENTION

Since the major policies under which HHS programs operate are set forth in HHS legislation and regulations, the Office of the Inspector General places high priority on review of HHS regulations and legislative proposals. To prevent loopholes that permit fraud, abuse, and waste, the OIG reviews proposed HHS regulations and legislation before they are approved by the Department. This early analysis prevents deficiencies that might otherwise remain undetected until audits or other reviews disclose that HHS funds have been inappropriately spent, or fraud or abuse has occurred. Our review incorporates the knowledge and experience of all OIG components.

During the period from October 1983 to March 1984, the OIG reviewed 55 HHS regulatory changes and 170 legislative proposals. This included 69 from the Health Care Financing Administration (HCFA), 30 from the Social Security Administration (SSA), 99 from the Public Health Service (PHS), 23 from the Office of Human Development Services (HDS), and 4 from other programs. The OIG reviewed a total of 131 regulatory and 354 legislative proposals during the year from April 1983 to March 1984.

MEDICARE PROSPECTIVE PAYMENT

The most important HHS regulation that the OIG reviewed during the Semiannual period from October 1983 to March 1984, was the final prospective payment regulation that made major changes in the way that Medicare reimburses hospitals for $44 billion in services to Medicare beneficiaries. The OIG recommended safeguards including: (1) penalty statements alerting physicians to possible penalties for fraudulent misrepresentation of patient data that is used to determine prospective payment amounts; (2) medical review of bills for a payment category that is subject to abuse; and (3) clearer sanction authority for those who defraud or abuse the payment system. HCFA adopted these safeguards in its final rule. The OIG is monitoring the implementation of prospective payment and will recommend any additional legislative or regulatory safeguards identified.

CHANGES IN REGULATIONS AND LEGISLATION

In addition to review of proposed changes in regulations and legislation, the OIG also recommends changes in existing regulations and legislation to safeguard HHS programs. These recommendations are transmitted to HHS and operating agencies in audits, inspections and other reports. OIG legisla-

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tive recommendations of this kind that have not been enacted are summarized on page 67 of this Report.

SANCTIONING AUTHORITY

The OIG has also made a number of recommendations to strengthen the statutory authority for sanctioning health care suppliers and providers for defrauding or abusing the Medicare or Medicaid programs. The OIG has recommended the legislative establishment of authority to:

1) Refuse to enter into or renew a Medicare provider agreement with an organization whose managers, directors, or owners have been convicted of (a) financial fraud or patient abuse or neglect in connection with the delivery of health care or services or against any other Federal, State or local government agency; or (b) unlawful manufacture, prescription, dispensing, or delivery of a controlled substance.

2) Exclude individuals convicted of (a) financial fraud or patient abuse or neglect in connection with the delivery of health care or against any other Federal, State or local government agency or (b) the unlawful manufacture, prescription, dispensing or delivery of a controlled substance from Medicare and Medicaid program participation;

3) Exclude those who have been sanctioned for defrauding or abusing the Medicaid program from participation in the Medicare program.

4) Permit unified judicial review of monetary penalties under the civil monetary penalties statute and Medicare and Medicaid suspensions imposed.

5) Expand subpoena power in civil monetary penalties proceedings.

6) Provide civil monetary penalties for claims submitted after the date of exclusion from Medicare and Medicaid pursuant to a Peer Review Organization determination.

7) Increase State share of civil monetary penalties awards to encourage State investigation and referral of Medicaid fraud cases.

8) Terminate Medicare and Medicaid participation where the owners, managers or directors of a provider or supplier have been convicted of Medicare or Medicaid related crimes.

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9) Terminate from Medicare and Medicaid participation individuals who have been sanctioned either by the denial of payment or by civil monetary penalties.

10) Exclude certain health care suppliers or other entities owned or controlled by individuals convicted of Medicare or Medicaid related crimes.

11) Exclude from participation in the Medicare and Medicaid programs persons who engage in conduct in violation of the anti-kickback provisions of the Social Security Act.

12) Exclude any entity that fails to grant immediate access, upon reasonable request, to the OIG for the purpose of review of records, documents, or other data necessary to the Inspector General in the performance of OIG statutory functions.

In addition, the OIG has recommended statutory amendments which would:

1) Reorganize the current fraud and abuse provisions of the Social Security Act to consolidate the provisions setting forth administrative remedies and criminal penalties for fraud and abuse in the Medicare and Medicaid programs into one section of the Act.

2) Set forth an express statute of limitations for civil monetary penalties proceedings.

3) Make several technical clarifying amendments to those statutes granting authority to control fraud and abuse.

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PRESIDENT'S COUNCIL ON
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CHAPTER VI

PRESIDENT'S COUNCIL ON INTEGRITY AND EFFICIENCY

President Reagan established the President's Council on Integrity and Efficiency (PCIE) in March 1981 to coordinate Governmentwide activities which attack waste and fraud in Government and to improve management processes. In addition to strengthening the role of the Inspectors General in performing audits and investigations to identify the sources of waste and fraud, the PCIE has focused on cooperative interagency activities which enhance the Federal Government's overall ability to combat fraud, abuse and waste. The DHHS OIG has been involved in a number of these projects.

Computer Security Project

COMPUTER FRAUD AND ABUSE

The Phase I analysis of computer-related fraud and abuse found lack of consistent case identification and incomplete responses to the Phase I questionnaire, particularly in the areas of systems controls, prior audits and reviews, and loss estimates. To verify these conclusions and to fill in the gaps in information, a task force, led by HHS has been established to conduct Phase II of the Project.

FRONT-END SECURITY

A special work group, the PCIE Front-End EDP Systems Review and Security, has been established under the Computer Security Project to: (1) clarify the roles and responsibilities of the OIGs and operational management in the EDP development process; (2) encourage priority use of resources on high risk areas; and (3) develop an effective audit tool looking at systems under development. The work group is now field testing materials in HHS, DoD and Treasury.

ELECTRONIC BILLING

A third work group of the project is conducting a vulnerability assessment to examine the adequacy of controls and procedures to prevent error and fraud in electronic billing by health care providers. Field work has been completed and findings are now being analyzed.

Computer Matching Project

FRONT-END VERIFICATION

A work group on Front-End Eligibility Verification Systems was established to identify: (1) information needed to determine eligibility for the AFDC,

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Medicaid, Food Stamp, and Unemployment Insurance Programs; (2) where that information is obtained; (3) which information is common and critical to all four programs; and (4) which States are using computerized front-end eligibility verification techniques.

STANDARDIZED FORMATS

The computer match committee is field testing four Standard Formats to facilitate computer matching in: (1) Assistance Programs; (2) Wage and Earnings; (3) Unemployment Insurance; and (4) Medical Payments. The formats will be tested in matches in 27 jurisdictions to identify duplicate unreported income and assistance payments.

MANAGER'S MATCHING GUIDE

We have developed a Manager's Guide to provide State government managers of benefit programs some practical advice on how to conduct cost effective computer matches. It covers such topics as clarifying expectations, determining the type and frequency of matches, front-end matches, overseeing data processing, the follow-up process, assuring privacy and due process, and cost/benefits determination. Focusing on the AFDC, Food Stamps and Medicaid programs, the guidance is based on the practical experience of those Federal, State and local officials who have been most directly involved in all phases of computer matching. Copies of the "Guide" are being circulated to interested officials at each level of government.

COMPUTER SCREEN CLEARINGHOUSE

The OIG is identifying sophisticated computer screens used to detect and prevent fraud and abuse in health provider programs. Once these computer applications have been determined, a clearinghouse will be established to share this information with all members of the health financing community.

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APPENDIX A

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Appendix A

UNENACTED LEGISLATIVE RECOMMENDATIONS

The following legislative recommendations have been made in specific OIG audits and other reports on preventing waste in HHS programs and have not yet been enacted by Congress. Recommendations discussed in this Report are referenced by page number. Legislative proposals relating to the OIG's own authority are contained in Chapter V of this Report. This list also does not include preliminary recommendations described in this Report which are still under consideration by the OIG.

Health Care Financing

- Second Surgical Opinions
  (Audit Control Number 03-30211)

  Require Medicare and Medicaid beneficiaries to seek a second surgical opinion for selected elective surgeries. (See page 25)

  Savings: $65 million for Medicaid and $135 million for Medicare in FY 1985, with increasing savings in succeeding years.

- Rounding Down of Medicare Part B Payments
  (Audit Control Number 03-42006)

  Require round down of odd-penny claims to the next lower dollar. (See page 26)

  Savings: $45 million in FY 1985, with increasing savings in succeeding years.

- Medicare Secondary Health Insurer for Certain Beneficiaries with Working Spouses - (Memorandum dated October 5, 1983)

  Permit Medicare to be the second payer for beneficiaries whose spouses work for employers who provide family health insurance.

  Savings: $345 million in FY 1985, with increasing savings in subsequent years.

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- Verification of service methods used by State Medicaid Agencies

  (Service Delivery Assessment — "The Medicaid Explanation of Benefits Requirement: A Brief Inquiry Concerning Its Implementation," dated April 1983)

  Allow States greater administrative flexibility in determining methods used to verify services provided to recipients for which payments are claimed.

  Savings: $3-5 million annually (75 percent of which is Federal).

Social Security Administration

- More frequent Social Security Deposits
  (Audit Control Number 13-32601)

  Accelerate State Social Security contribution deposits by adopting the private sector schedule. (See page 39)

  Savings: $988 million in contribution receipts and $480 million in interest income over 5 years.

- Duplication of Shelter Allowance
  (Audit Control Number 01-20252)

  Require States to consider shelter allowance received from other Federal programs in determining AFDC programs. (See page 40)

  Savings: $377 million annually.

Public Health Service

- Recoveries of Construction Grant Funds (Audit Control Number 12-43217)

  Reporting procedures and interest penalties should be strengthened to improve recovery of construction grant funds in the Health Professions Teaching Facilities, Nursing Training Facilities and Community Mental Health Centers Program. (See page 44)

  Savings: Up to $82 million annually.

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APPENDIX B

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Appendix B

ANALYSIS OF COST SAVINGS OCTOBER 1983 THRU MARCH 1984

This analysis includes savings resulting from management commitment not to expend funds or to more efficiently use resources. Also shown are recoveries which include: (1) management commitments to seek recoveries of funds based on OIG recommendations; and (2) fines, penalties, recoveries and restitutions from investigations.

OIG RECOMMENDATIONS	ACTION TAKEN	$ MILLIONS
Replace the monthly deposit requirement of Social Security contributions for State and local employers with the private sector deposit schedule. (ACN: 13-32601)	Congress has enacted legislation to accelerate the deposit schedule from monthly to twice monthly.	1,332.0
Change the computational assumptions when calculating the lump-sum prepayment of future liability for military service credits. (ACN: 13-32686)	SSA concurred with our findings and the Office of the Actuary computed the lump-sum transfer based on our recommendation.	56.0
Eliminate SSA's involvement in approving and paying fees of attorneys who assisted applicants in their efforts to obtain benefits. (ACN: 13-32694)	SSA concurred with our finding and estimated savings in FY 1984 of $2.9 million and continuing thereafter at an annual increase of 10 percent.	2.9
Revise a university's sample methodology for estimating the allocations of indirect costs. (ACN: 09-47089)	The Division of Cost Allocation agreed with our finding and required the University to use standard allocation bases.	14.0
Eliminate unallowable and overstated costs from indirect cost rate proposal. (ACN: 07-47002)	As a result of this audit, the Division of Cost Allocation was able to establish indirect cost rates which were more equitable than those proposed.	4.8
Eliminate excessive occupancy rates charged through a State's cost allocation plan and a public assistance administrative cost allocation system. (ACN: 06-30250)	A settlement was negotiated with the State, by the Division of Cost Allocation, which affected HHS, USDA, DOL and DOE.	2.0
Establish procedures to ensure Title XIX payments for services provided by State schools were reasonably related to cost; also review cost reports submitted by State schools and make appropriate adjustments. (ACN: 06-10151)	The State concurred with our findings and made a financial adjustment for overpayments of over $1.8 million.	1.8
Reduce excessive amounts of cash on hand. (ACN: 06-31300)	Procedures established by auditees to minimize cash balances should save the Federal Government interest of more than $1.8 million per year.	1.8

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Expand employment opportunities for developmentally disabled young adults.	OHDS is mobilizing existing networks, enlisting private sector support, and including employment projects in DD discretionary grants to create 25,000 jobs for DD young adults.	126.0
Prompt action on disability payments following a legal judgment by the Office of Hearings and Appeals (OHA).	SSA has identified and flagged 4,969 cases requiring timely termination this fiscal year.	67.0
Tighten processing of returned checks in the SSI program.	SSA is tightening the remittance process.	4.0
Eliminate Medicare participation in collection agency fees where the agency refused to accept Medicare accounts or where legal title transferred.	HCFA issued appropriate instructions which limit Medicare participation in collection agency fees.	35.0
Limit treatment of mycotic nails to that which is therapeutic, require podiatrist to identify on bill the nail avulsed and establish 60-day utilization guidelines.	HCFA agreed with our recommendations.	10.0
Establish other codes to reflect cost of less expensive flotation pads which had been developed.	Contractor agreed with our recommendations and established four new codes for processing such claims.	1.0
Revise one Medicare contractor's prepayment edit definition to ensure that anesthesia and assistant surgery services are reimbursed at proper rate.	Contractor accepted findings and modified its prepayment edit definitions.	.8
Review one Medicare carrier's billing codes and develop and implement a new Medicare edit for physician visits to nursing home patients.	Contractor accepted and implemented our recommendations.	.35
Clarifying instructions be issued by HCFA on policies for billing for disposable humidifiers and standby oxygen system.	HCFA issued new instructions which implement our recommendations.	.28
Savings resulting from investigations.	Management commitments to take action.	3.4
	TOTAL (in Millions)	
	1. Savings (in millions)	1,663.1
	2. Recoveries	
	a. Agreements to recover	114.8
	b. Fines, Penalties, etc.	14.9
	GRAND TOTAL	1,792.8

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